will become interested and active in the long-range, nation-wide effort.

Q. Is it not true that the President of the United States has stated that he is opposed to the plan of medical service proposed in the Wagner National Health Bill?

A. Yes, he has so stated.

Q. Does not this official pronouncement indicate that the possibility of dangerous, revolutionary legislation is past?

A. In the present session of Congress probably —in the future, no. The official attitude of the Administration—as voiced by the President—is the result of three prime considerations:

1. 1940 is a presidential election year. The Wagner National Health Bill, if enacted into law, would necessitate the expenditure of huge sums—ultimately possibly as much as $3,000,000,000 per year.—The expenditures would further unbalance the budget. As a political issue it is unpopular.

2. Vast sums are desired by the Administration for national defense. Diverting substantial amounts for expenditure for public health would lessen the chances of securing them or result in reducing the amounts that might be voted by the Congress for this purpose.

At this time the National Defense issue is more popular and of greater political value than the so-called Health Issue.

3. Opposition to the Wagner National Health Bill became so widespread and effective that it became evident that its advocacy was temporarily politically injudicious. *This in no way affects the issue. It simply means that action is temporarily postponed and the real problem remains to be solved. It is essential that the public be informed —so that when the test comes it will know the facts.*

Q. Have medical journals published articles or editorials dealing with the National Physicians' Committee for the Extension of Medical Service?

A. Yes. On December 2 the AMA Journal carried the story of the organization of the institution.

In the December issue of CALIFORNIA AND WESTERN MEDICINE, *Dr. George Kress ran a one-half page editorial and republished—verbatim—the text of the brochure—"The Achilles Heel of American Medicine."*

During December and January practically every medical journal and bulletin published comment.

No enterprise in the range of human experience can rank with learning. By it alone man rises above dumb creatures. If, therefore, we have received nothing else so good as the mind, what should be more worth cultivating? No quest of gold or worldly power has, in the long run, ever brought like gratification. No other adventure is to be compared with it. Through it civilization and all man's higher achievements have been won.—Leon J. Richardson.

Life is not mere living, but the enjoyment of health.—Martial.

CLINICAL NOTES AND CASE REPORTS

PSEUDOMUCINOUS CYST OF OVARY WITH ASSOCIATED OVARIAN DERMOID

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STATISTICS vary somewhat as to the incidence of pseudomucinous ovarian cysts, as compared with the serous type. In a total of 331 cases of ovarian cysts operated on by himself, T. Wilson [1] found 144, or 43.5 per cent, to be pseudomucinous cystadenomata. According to Taylor,[2] various other writers give the incidence of this type of ovarian cyst as from 30.6 to 53.6 per cent of all ovarian newgrowths. Forty-five per cent is considered a good general average. Masson and Hamrick,[3] in a series of thirty cases of pseudomucinous ovarian cysts, found six, or 27.2 per cent, of the benign cysts to contain papillomata..

Very little mention is made anywhere of the coexistence in the same tumor mass of a pseudomucinous ovarian cyst with a dermoid. Clear-cut case reports seem to be almost absent in recent literature, except for that of R. Wilson and Sims,[4] who removed such a tumor, measuring 65 by 45 by 9 centimeters, from a negress thirty-nine years of age. Norris [5] has described an ovarian dermoid complicated by an eighty-pound ovarian cyst, presumably of the pseudomucinous type.

Green-Armytage,[6] Frank,[7] Graves,[8] and others remark that ovarian dermoids often occur in combination with pseudomucinous cysts, the two types being found either coexisting in the same ovary, or in contralateral ovaries. Arnsperger [9] is quoted by Ewing,[10] Koucky,[11] and others. He believes that 14 per cent of multilocular cystadenomata are associated with ovarian dermoids, either on the same or opposite side. There seems insufficient evidence at present to accept these figures at face value, as Arnsperger [9] does not give enough details to war-

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1 Wilson, T.: Gelatinous Glandular Cysts of the Ovary and the So-called Pseudomyxoma of the Peritoneum, Proc. Roy. Med. Sect. Obst. and Gynec., 6:9-42, 1912-1913.

2 Taylor, H. C., Jr.: Malignant and Semimalignant Tumors of the Ovary, Surg. Gynec. and Obst., 48:204, 1929.

3 Masson, J. C., and Hamrick, R. A.: Pseudomucinous Cystadenoma of Ovary: Analysis of Thirty Cases in Which Cysts Were not Ruptured Before Operation, Surg. Gynec., and Obstet., 50:752 (April), 1930.

4 Wilson, R. R., and Sims, T. J.: Dermoid Cyst of Ovary, Combined with Large Pseudomucinous Cyst, J. Kansas M. Soc., 32:151 (May), 1931.

5 Norris, quoted by Frank, R. T.: Reference No. 7.

6 Green-Armytage, V. B.: Postgraduate Surgery, Vol. 2, Section 4, on "Tumours of the Ovary," pp. 2641 and 2646, New York, D. Appleton-Century Company, 1936.

7 Frank, R. T.: "Gynecological and Obstetrical Pathology," p. 418, New York and London, D. Appleton & Company, 1922.

8 Graves, W. P.: "Gynecology," p. 344, Philadelphia and London, 1916.

9 Arnsperger, H.: Zur Lehre von den sogenannten Dermoidcysten des Ovarium, Virch. A., 156:1-36, 1899.

10 Ewing, J.: "Neoplastic Diseases," third edition, p. 656, Philadelphia and London, W. B. Saunders Company, 1928.

11 Koucky, J. D.: Ovarian Dermoids: A Study of One Hundred Consecutive Cases, Ann. Surg., 81:821 (April), 1925.

rant the above conclusions. Anspach[12] and Kelly[13] do not mention the subject. Hertzler[14] and Meigs[15] remark that such instances of coexistence have been noted, but say very little about it.

The fact that the pseudomucinous cystoma may occur in the same tumor mass with an ovarian dermoid cyst has given rise to the belief that the two are embryonic tumors and have a common origin. Hertzler,[14] Ribbert,[16] Meigs,[15] and others consider this as a probability. Ribbert[16] believes that the pseudomucin cysts are the entodermal portion of a dermoid anlage, and that these cysts are embryomata in which only the entodermal layer has developed the cyst representing rudimentary intestine. Graves[8] also remarks on the similarity of its secreting cells to those of the intestinal tract, and therefore concludes that the tumor originated from embryonal entoderm. Needless to say, absolute proof is yet lacking.

Because of the paucity of actual case reports in recent literature, we present the following report.

REPORT OF CASE

Mrs. F. S., age 52, white, widow, came to us first on February 21, 1939, for relief of fatigue, and an enlarging abdomen. Past history was essentially negative, except for a series of painful boils which lasted from August, 1937, to May, 1938. Following a series of staphylococcus toxoid injections, there have been no recurrences. At the age of twenty-two she aborted spontaneously at three weeks. There have been no other pregnancies. Menopause seven years ago at forty-five years of age. Before that the menses were always regular and painless. Six months prior to her visit to us in February, she had begun to notice a slowly enlarging lower abdomen and a tendency to ready fatigue. These factors progressed slowly and steadily until she came to us. She had a constant feeling of crowding and pressure low in the abdomen and pelvis. This had become very noticeable during the preceding week. The patient's work made it necessary for her to spend much time daily on her feet.

General physical examination was essentially negative. The lower abdomen was enlarged to the size of a five and one-half months' pregnancy, with the main tumor mass lying to the right of the midline. The tumor was not ballotable, and on pelvic examination the cervical os was up near the roof of the vaginal vault, almost impossible to locate on ordinary examination. No findings were noted suggesting pregnancy. The tumor felt hard and fixed, and no tenderness was elicited, nor was any fluctuation noted. No ascites, and no level of shifting flank dullness. Moderate pitting edema of both feet was present. No cachexia. The urine was normal. Blood Wassermann and Kahn were negative. Blood count showed: red cells 3,900,000, hemoglobin (Newcomer) 75 per cent, white cells 15,950, with 76 per cent neutrophils, 15 small lymphocytes, 3 large lymphocytes, 5 transitional, and 1 eosinophil.

The abdomen was opened under cyclopropane anesthesia on February 25, 1939, through a midline incision. No ascites was found. Very few adhesions were found and these were of a plastic nature. A large multilocular cystic tumor was then encountered. As this was gradually mobilized, it was found to be replacing the right ovary. It rested immediately on another smaller and smoother cystic tumor replacing the left ovary. The two tumor masses were firmly impacted on top of a small myomatous uterus with the fundus pushed over into the right side of the pelvic cavity. Both tumor masses were mobilized and extirpated, and a supravaginal amputation of the uterus was done in the usual manner. The appendix was removed. Convalescence was normal except for a moderate attack of pyelocystitis, which occurred three weeks after operation. This subsided rapidly and has not recurred.

The larger right ovarian tumor was ovoid in shape and weighed 2,046 grams. It measured about 15 centimeters in diameter. On sectioning, it was found to be a multilocular cystic tumor, the various compartments being packed with mucinous material. One of the cysts, larger than the rest (7 centimeters in diameter) contained thick sebaceous material, intermingled with hair and a poorly developed bony process. Microscopically, two types of neoplastic structure were seen. One section showed a picture of a dermoid cyst with a lining of stratified squamous epithelium, with sebaceous glands and hair follicles beneath. The others showed many cystic spaces and papillary projections, with a lining of tall columnar epithelium. These cells were packed and distorted by large globules of mucoid material. This material was seen within the spaces, and in some regions stained faintly, while in others it took a deep purple-red stain much as does calcium deposition on the tissues.

The smaller left ovarian tumor weighed 453.6 grams and measured 10 centimeters in diameter. It was unilocular and contained thick inspissated, fatty material, but no hair. On microscopy, its wall consisted of nondescript fibrous tissue, with one small patch of stratified squamous epithelium.

The uterus contained a typical myoma, and the appendix was of the fibrotic obliterative type.

It is interesting to note that bilateral ovarian cysts were present, one of these in the right ovary being associated with a large pseudomucinous ovarian cyst.

COMMENT

1. Although many writers state that ovarian pseudomucinous cysts often occur in the same tumor mass with a dermoid cyst, no definite statistics are available.

2. Good evidence suggests that both tumors are derived from embryonal rests, the pseudomucinous cysts arising from the entoderm, while the dermoid elements arise from the ectoderm.

3. Very few case reports of the combination are reported.

4. The case of a large pseudomucinous ovarian cyst in combination with a dermoid cyst is presented. There was also a dermoid of the opposite ovary.

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12 Anspach, B. M.: "Gynecology," pp. 384 and 388, Philadelphia and London, J. B. Lippincott Company, 1921.

13 Kelly, H. A.: "Gynecology," p. 736, New York and London, D. Appleton & Company, 1928.

14 Hertzler, A. E.: "Surgical Pathology of the Female Generative Organs," p. 110, Philadelphia, Montreal, and London, J. B. Lippincott Company, 1932.

15 Meigs, J. V.: "Tumors of the Pelvic Organs," p. 248, New York, The Macmillan Company, 1934.

16 Ribbert, H.: "Geschwulstlehre," p. 650, Bonn, F. Cohen, 1904.

HIPPOCRATES' APHORISMS

By Moses Scholtz, M. D.
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SECTION ONE

1. "Life is short and Art is long,"
Says wise Hippocrates;
Be cautious, and proceed with care,
In dealing with disease.

Thy judgment and experience
May fail you, as your skill;
Seek from thy patient and his nurse
Their help and their good will.

2. Do not permit sick persons to be drained,
Unless the body's poisons call for purging;
And do not cause such drain by giving drugs,
Unless the indications are quite urging.